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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DORA MARIA MENDEZ LUNA 15321 Pintura Drive Hacienda Heights, CA 91745 Registered Nurse License No. 415910 Respondent.	Case No. 2009-113 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 29, 1988, the Board of Registered Nursing (Board) issued Registered Nurse License Number 415910 to Dora Maria Mendez Luna (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

7. California Code of Regulations, title 16, section 1443.5, states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

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(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

8. Code Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

BACKGROUND

9. On or about December 7, 2006, a ten year old patient[1] was admitted to the Emergency Department of Kaiser Hospital, Baldwin Park, with symptoms of abdominal pain, nausea and vomiting. A physician prescribed a high dosage of Promethazine (Phenegan) 25 mg IVP, which was to be administered by the Respondent.

10. Respondent failed to administer the full dose prescribed by the physician, and only gave 12 mg IVP of Promethazine (one-half of the ordered dose) to the patient without first discussing her concerns or findings about the original order with the prescribing physician.

11. Once instructed by a supervisor, Respondent consulted with the physician, at which time she informed him that she had not given the full ordered dosage of

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1. All patient and physician names are withheld for purposes of privacy and will be released upon receipt of a proper request for discovery from the Respondent.

Promethazine. The physician recalculated the dosage, and ordered Respondent to administer the remaining 13 mg IVP of the original Promethazine 25 mg IVP medication order.

12. Again, Respondent failed to administer the full remaining dosage to the patient. Instead, Respondent only administered an additional 6 mg IVP of Promethazein to the patient, for a total of 18 mg IVP.

13. At not time did the Respondent communicate to the physician that she again failed to administer the full dosage of Promethazine 25 mg IVP to the patient.

14. A review of the patient's medical records reveals that Respondent documented that the patient received Promethazine 18 mg IVP at one time, when in fact, the dosage was administered at two separate times. In addition, Respondent indicated that the physician was aware that Respondent only administered Promethazine18 mg IVP, instead of the ordered 25 mg IVP of Promethazine, when in fact, Respondent failed to communicate this fact to the physician. Further, Respondent failed to document the patient's symptoms of diarrhea or vomiting, the patient's response to the medication's administration, and Respondent's ongoing assessments of the patient over the five hour period in which the patient was admitted to the hospital.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

15. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, sections 1443 and 1443.5, in that Respondent demonstrated incompetence in carrying out usual certified or licensed nursing functions with regard to the circumstances discussed in paragraphs 9 through 14, above, as follows:

a. Respondent failed to follow a physician's orders to administer the full dosage of a prescribed medication, and failed to communicate with the physician when the medication was not prescribed as ordered. As a result, Respondent failed to implement, and interfered with, the treatment plan recommended by the physician and the coordination of care for the patient.

b. Respondent failed to document the patient's symptoms of diarrhea or vomiting.

c. Respondent failed to document the patient's response to the medication's administration, as well as Respondent's own ongoing assessments of the patient over the five hour period in which the patient was admitted to the hospital.

d. Respondent made false and incorrect entries in the patient's medical records, in that Respondent documented that she administered Promethazine 18 mg IVP as one dose, and indicated that the physician was aware of the decreased dosage, when in fact, the physician was not aware of the decreased dosage, and the medication was administered at two different times.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), in that Respondent committed unprofessional conduct in the practice of nursing by failing to follow physician's orders regarding the administration of medication, and/or, failed to correctly document entries in the patient's medical records, as more fully discussed in paragraphs 9 through 14, above, which are herein incorporated by reference as set forth in whole.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 415910, issued to Dora Maria Mendez Luna;

2. Ordering Dora Maria Mendez Luna to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 11/17/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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